## Leg Symptoms in Veterans

To THE EDITOR: I read the article by Oboler and colleagues concerning leg symptoms in outpatient veterans in the September 1991 issue.[1]

The article does not mention spinal stenosis as a cause of leg symptoms in "outpatient veterans." The authors discuss peripheral neuropathy, peripheral vascular disease, and metabolic leg cramps. A differential diagnosis of each one of these entities would include spinal stenosis, sometimes referred to as neurogenic claudication.

A common symptomatic differentiation between lumbar spinal stenosis and the other causes of leg pains includes the dramatic relief of symptoms when the patient sits down as opposed to standing, walking, or lying down. Although neurologic findings are often meager, a computed tomographic scan or magnetic resonance imaging will usually lead to the correct diagnosis.

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REFERENCE

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### Drs Oboler, Prochazka, and Meyer Respond

To THE EDITOR: As pointed out by Dr Slater, we did not address spinal stenosis in our paper on leg symptoms in veterans. Initially we planned to include claudication as one of the target symptoms. Since spinal stenosis typically presents as exertional leg pain exacerbated by spinal extension but with intact peripheral pulses, patients with spinal stenosis would likely have been included in the group with symptoms of claudication. In piloting our questionnaire, however, we found that the question, "Do you have pain in your legs when you walk that is relieved with rest?" was too nonspecific, as patients with known degenerative joint disease, radiculopathy, and peripheral vascular disease all answered in the affirmative. We therefore did not include exertional leg symptoms in our survey. We agree that spinal stenosis may be a common problem in this population.

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## Response Bias

To THE EDITOR: I was dismayed to see in the August 1991 issue Baldwin and colleagues[1] cite Guadagnoli and Cunningham[2] and Sobal and Ferentz[3] in support of their remarks about response bias. Blalock and Dial[4] have challenged some of the conclusions drawn by Guadagnoli and Cunningham and by Sobal and Ferentz, especially the conclusion that low response rates are not as serious a problem as survey researchers have traditionally thought. Stated briefly, our chief objections were that lack of bias in one variable does not necessarily imply lack of bias in any other variable, and tests for univariate bias do not address the possibility of biases in bivariate or multivariate distributions.

I shall add another objection that perhaps we should have raised earlier: The results of response bias tests do not generalize from one study to another. There are stronger reasons to expect response bias in some populations, and with some survey instruments, than in others. In the case of a survey of medical students on the topic of mistreatment, one might reasonably expect a bias in favor of response by students who are both angry about mistreatment and not too repressed or distrustful to answer questions about it.

I hasten to add that this should in no way diminish the level of concern aroused by the disturbing situation that Baldwin, Daugherty, and Eckenfels describe.

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2. Guadagnoli E, Cunningham S: The effects of non-response and late response on a survey of physician attitudes. Evaluat Health Profess 1989; 12:318-328

3. Sobal J, Ferentz KS: Comparing physicians' responses to the first and second mailings of a questionnaire. Evaluat Health Profess 1989; 12:329-339

4. Blalock RR, Dial TH: Assessing representativeness in surveys of physicians (Letter). Evaluat Health Profess 1990; 13:364-366

## Concurrent Munchausen's and 'VIP' Syndromes

To THE EDITOR: Patients with a variety of psychiatric conditions often evoke uncomfortable feelings in their clinicians, which may interfere with objectivity and clinical judgment and thus threaten optimal care. Groves describes four kinds of provocative or "hateful" patients[1]: dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers. Although clinicians are generally aware of such difficult patients, the concurrence of two provocative clinical syndromes poses an additional risk of inferior care.

*Report of a Case*

A 43-year-old woman presented with recurrent fever, nausea, severe back pain, and constipation. Before admission, she had contacted the hospital's fund-raising department to inform them that she was a relative of the President of the United States and a personal friend of the hospital's chief executive officer, and she requested a special suite during her stay. At that point, she was referred to the attending internist as a new patient. She related a history of many operations, including hernia repair, cholecystectomy, drainage of a subphrenic abscess, hemicolectomy, and repeated lysis of surgical adhesions. She said she was allergic to penicillin, nonsteroidal anti-inflammatory drugs, phenytoin (previously called diphenylhydantoin), and several other drugs (yet, later in the hospital course she claimed to have a history of seizures for which she requested diazepam and phenytoin). The patient was medically well informed and said that she was a physician as well as having a PhD, having attended McGill University Medical School.

On physical examination, she was tearful and had multiple abdominal scars. Examination of the buttocks revealed extensive induration and scarring, which the patient said were sites of previous biopsies for "a sclerosing disease." Screening laboratory tests revealed mild anemia and a slightly elevated thyroid-stimulating hormone level.

During her hospital course, the patient was demanding